ALABAMA MEDICAID SPECIFICATIONS

NCPDP VERSION D.Ø

ALABAMA SPECIFICS FOR PHARMACY

Note: *The information in this document is subject to change. Please refer to the effective date located in the footer of this document for the latest information available.*

Version 1.3

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General Information and Requirements

Testing Procedures

Once a vendor has developed a program following the guidelines stated in this manual, they must test the program for approval. Upon approval, instructions will be given for the submission of production claims. For more information, please call (334) 215-0111 or 1-800-456-1242.

Help Desk

The EMC Helpdesk is available to providers and vendors to answer questions, concerns, or to address any problems which may occur during transmission. The help desk can be reached at the following:

Phone	Writing	E-mail
(800) 456-1242	Hewlett-Packard Enterprise Services	AlabamaSystemsEMC@hp.com
(334) 215-0111	Attn: EMC Helpdesk	
(334) 215-4272 (fax)	301 Technacenter Drive	
	Montgomery, AL 36117	

Issues

The following paragraphs give specific information regarding the implementation of NCDPD Version D.Ø. Each of the following paragraphs gives information on specific issues regarding Alabama Medicaid transmissions.

Field Justification

Due to the variable format, field justification is not applicable. However, if you choose to pad each field, all alpha-numeric fields should be left justified and numeric fields should be right justified.

Data Element Usage

In NCPDP Version D.Ø, the field/data element usage is defined as:

M = Mandatory
R = Required
Q = Qualified Requirement
I = Informational Only
O = Optional

The Data Element Usage column listed per request/response segment is from the Telecommunication Standard Implementation Guide. Please reference the AL Requirements columns for any specific requirements for the selected field/data element.

Within a segment, situational or optional fields are submitted after the mandatory and required fields/data elements.

Some fields may be repeated or sent more than once. These fields are denoted with ***R***, in the Data Element Usage column. The number inside the ( ) represents the number of times the field can be repeated.

If the AL Requirements column is N/A, the value sent for the data element isn't used in processing the request. For example, the Processor Control Number (1Ø4-A4) in the Transaction Segment can be sent as all spaces to meet the mandatory requirement.

Co-Pay Exemption

The patient segment is an optional segment. There are two fields, also optional, that we will capture from this segment, if the segment is sent. Below is a table of these fields and the values we will default to if the segment and/or fields are not sent.

When the Place of Service indicates Long Term Care (LTC), the recipient will be considered exempt from co-pay. In version 5.1 the field was named Patient Location. For D.Ø, the field was renamed to Place of Service.

Field	Segment	NCPDP Field #	Valid Values (Valid values appear in ***bold***.)	Default Value	AL Requirements
PLACE OF SERVICE	Patient	3Ø7-C7	Refer to External Code List for values.	Blank	It will be assumed that the recipient is not in an LTC facility. Values of 31, 32, or 54 will indicate LTC.

A pregnancy indicator field (335-2C) exists in NCPDP D.Ø on the patient segment. A value of '2' in this field will indicate that the recipient is pregnant. When the Pregnancy Indicator is '2', the recipient will be considered exempt from co-pay. The table below shows the basic data for this field.

Field	Segment	NCPDP Field #	Valid Values	Default Value	AL Requirements
PREGNANCY INDICATOR	Patient	335-2C	Blank=Not Specified 1=Not pregnant 2=Pregnant	Blank	It will be assumed that the recipient is not pregnant.

The claim segment is mandatory for a B1 Billing request. A prior authorization field (461-EU) exists in NCPDP D.Ø on the claim segment. This field (461-EU) is optional. A value of '1' in this field will indicate a prior authorization number is contained in the 462-EV field. A value of '4' in 461-EU will indicate the recipient is a Native American Indian with an active user letter and is exempt from co-payment. For additional information on exemption from copay, please reference the current Provider Manual for Pharmacy found at http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx.

Field	Segment	NCPDP Field #	Valid Values	Default Value	AL Requirements
PRIOR AUTHORIZA-TION TYPE CODE	Claim	461-EU	Blank=Not Specified 1=Prior Authorization 4= Exemption from Copay	Blank	It will be assumed that the recipient is not exempt from co-payment.

Other Insurance

NCPDP D.Ø allows the submission of up to 9 instances of other insurance information. We will sum the values up (field 431-DV) and this value will become the TPL amount. In the Other Payer Amount Paid Qualifier (342-HC) field, the amount paid by the other payer should be designated with a value of "Ø7" (Drug Benefit) or a value of "Ø9" (Compound Preparation Cost). Other valid qualifier values can be submitted and will not result in a rejection, but values other than "Ø7" or "Ø9" will not be summed into the TPL amount.

New Fields Related to COB processing

Version D.0 has some additional fields available in the COB segment to capture other payer patient responsibility data. We will begin capturing these fields and will use them in determining the final price to be paid. The new fields are Other Payer-Patient Responsibility Amount Qualifier (351-NP) and Other Payer-Patient Responsibility Amount (352-NQ). These fields are now required and 352-NQ must be greater than zero when the Other Coverage Code submitted (3Ø8-C8) has a value of 02, 03, or 04. The Other Payer-Patient Responsibility Amount Qualifier (351-NP) should be submitted with a value of "06" to denote the total amount of patient responsibility.

We will use the Other Payer-Patient Responsibility Amount, in addition to the value submitted in the Other Payer Amount Paid (431-DV) to determine Medicaid's responsibility on the claim. In general, Alabama Medicaid will be responsible for the amount submitted in the Other Payer-Patient Responsibility Amount (352-NQ), minus any applicable Medicaid copay or other adjustments based on Alabama Medicaid policy.

Compound Drugs

Compound drug billing is enhanced with version D.Ø to allow all NDC's that are part of a compound to be billed on the same transaction. As a reminder, a compound drug is identified when data element 4Ø6-D6 Compound Code is equal to "2".

- Alabama Medicaid will allow up to 25 NDC's/ingredients to be sent per claim.
- Alabama Medicaid will reject compound claims if one or more NDC's is "non-covered".
- For compound claims with one or more non-covered ingredients, a value of "8" should be submitted in field 42Ø -DK (Submission Clarification Code) to allow for payment on the remaining covered NDC's. Version 5.1 only allowed one occurrence for Submission Clarification Code. Version D.Ø allows a maximum of 3 occurrences. All three occurrences will be reviewed during processing of the claim. When at least one of the occurrences is "8" or "08", the claim will be processed for the approved ingredient(s).

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Basis of Reimbursement Determination

Field 522-FM, *Basis of Reimbursement Determination* is an optional field that can be returned on a paid or duplicate billing transaction. This field explains how the drug ingredient cost was derived; whether AWP, DOJ, FUL, SMAC, WAC, or AAC (As of September 22, 2010, AWP and DOJ pricing are no longer used for Alabama Medicaid drug pricing). The table below shows how the basis of reimbursement values will be set in relation to the rate used in calculating the paid amount for the claim.

Value*	Price Type Used	Description
Ø		Not specified
1	**NA – this value will be returned when the billed amount is less than the calculated allowed amount**	**Ingredient Cost Paid as Submitted**
2		Ingredient Cost Reduced to AWP Pricing
3	**AWP**	Ingredient Cost Reduced to AWP Less X% Pricing
4		**Usual & Customary Paid as Submitted**
5		Paid Lower of Ingredient Cost Plus Fees Versus Usual & Customary

Value*	Price Type Used	Description
6	**SMAC or FUL**	**MAC Pricing Ingredient Cost Paid**
7		MAC Pricing Ingredient Cost Reduced to MAC
8		Contract Pricing
9	**AAC**	**Acquisition Pricing**
1Ø		ASP (Average Sales Price)
11		AMP (Average Manufacturer Price)
12		34ØB/Disproportionate Share/Public Health Service Pricing
13	**WAC**	**WAC (Wholesale Acquisition Cost)**
14		**Other Payer-Patient Responsibility Amount**
15		Patient Pay Amount
16		Coupon Payment
17		Special Patient Reimbursement

***Valid values for Alabama appear in **Bold.**

Rejection Codes

A billing transaction (B1) can potentially be responded to with a rejected response, a duplicate response, or a paid response. The format of these response transactions will follow the variable requirements of the version D.Ø standard. For reject responses, Medicaid will return the corresponding four-digit internal error code for the NCPDP reject code in the Response Message Segment, field 5Ø4-F4 (Message). The error codes will be preceded by two digits indicating how many error codes are being returned. In addition, text descriptions for these error codes will be placed in the Response Status segment, field 526-FQ (Additional message information). These text descriptions will be separated by a semi-colon.

Reversal Request Format Changes

The claim reversal transaction, or B2 (value of field 1Ø3-A3 Transaction Code in NCPDP specs), is the transaction by which a provider will submit a reversal transaction. Alabama Medicaid supports a single (one) reversal transaction in a B2 request.

The service provider ID, date of service, RX number and NDC (product/service ID) are also required to be sent on a reversal to further clarify that we have found the correct ICN to reverse. If the service provider ID, date of service, RX number and NDC do not match the paid claim exactly, the claim reversal request will be rejected accordingly.

Providers should contact their software vendor for issue(s) on processing a claim reversal.

Changes to the handling of Usual & Customary / Gross Amount Due fields

Effective April 13, 2010, for B1 transactions, the usual and customary (field 426-DQ) will be captured and compared to the amount submitted in the gross amount due (field 43Ø-DU). The lower of these fields will be used by the system to determine the final price to be paid by comparing the lowest submitted amount to the calculated price based on the Alabama Medicaid drug pricing file for the NDC submitted.

Prescription Origin Code Field now required

419-DJ, Prescription Origin Code will be a required element in B1 (Billing) D.Ø transmissions. A B1 Claim will reject when the Prescription Origin Code isn't provided in the transmission. Prescription Origin Code identifies the source of the prescription. A complete list of the values and descriptions can be found for 419-DJ in the Billing Request Transaction (B1 Request) section.

Billing Request Transaction (B1 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card Issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	x(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		1Ø digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	x(1Ø)	1Ø		N/A

Patient Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø1 = Patient	Ø1 = Patient ID Segment is situational.
3Ø4-C4	DATE OF BIRTH	R	Date of birth of patient.	9(8)	8		
3Ø5-C5	PATIENT GENDER CODE	R	Code indicating the gender of the individual.	9(1)	1	Ø= Not Specified 1 = Male 2 = Female	
311-CB	PATIENT LAST NAME	R	Individual last name.	x(15)	15		
3Ø7-C7	PLACE OF SERVICE	Q	Code identifying the place where a drug or service is dispensed or administered.	9(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	31 = Skilled Nursing Facility 32 = Nursing Facility 54 = Intermediate Care Facility/Mentally Retarded 31, 32 and 54 will set LTC (long term care). If field not sent, default will be space.
335-2C	PREGNANCY INDICATOR	Q	Code indicating the patient as pregnant or non-pregnant.	x(1)	1	Blank=Not Specified 1= Not pregnant 2= Pregnant	If field not sent, default will be blank.
35Ø-HN	PATIENT E-MAIL ADDRESS	I	The E-Mail address of the patient (member).	x(8Ø)	8Ø		
384-4X	PATIENT RESIDENCE	Q	Code identifying the patient's place of residence.	9(2)	2	Ø = Not Specified. 1 = Home 2 = Skilled Nursing Facility 3 = Nursing Facility. 4 = Assisted Living Facility 5 = Custodial Care Facility 6 = Group Home 7 = Inpatient Psychiatric Facility 8 = Psychiatric Facility – Partial Hospitalization 9 = Intermediate Care Facility/Mentally Retarded 1Ø = Residential Substance Abuse Treatment Facility 11 = Hospice 12 = Psychiatric Residential Treatment Facility 13 = Comprehensive Inpatient Rehabilitation Facility 14 = Homeless Shelter 15 = Correctional Institution	

Insurance Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø4 = Insurance	Ø4 = Insurance Segment is mandatory.
3Ø2-C2	CARDHOLDER ID	M	Insurance ID assigned to the cardholder.	x(2Ø)	2Ø		13 digit Medicaid ID number.
312-CC	CARDHOLDER FIRST NAME	Q	Individual first name.	x(12)	12		Required. Enter the recipient's first name. Alpha only.
313-CD	CARDHOLDER LAST NAME	Q	Individual last name.	x(15)	15		Required. Enter the recipient's last name. Alpha only.
359-2A	MEDIGAP ID	Q	Required, if known, when patient has Medigap coverage.	x(2Ø)	2Ø		
36Ø-2B	MEDICAID INDICATOR	Q	Required, if known, when patient has Medigap coverage.	X(2)	2	See Section II, Appendix C– UNITED STATES AND CANADIAN PROVINCE POSTAL SERVICE ABBREVIATIONS	
361-2D	PROVIDER ACCEPT ASSIGNMENT INDICATOR	Q	Required if necessary for state/federal/regulatory agency programs.	X(1)	1	Y = Assigned – Provider accepts assignment N = Not Assigned – Provider does not accept assignment	
997-G2	CMS PART D DEFINED QUALIFIED FACILITY	Q	Required if specified in trading partner agreement.	X(1)	1	Y = Yes=CMS qualified facility N = No=Not a CMS qualified facility	

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø7 = Claim	Ø7 = Claim Segment is mandatory.
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Twelve digit numeric prescription number.
436-E1	PRODUCT/SERVICE ID QUALIFIER	M	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	x(2)	2	See Appendix K - Product/Service Qualifier	Ø3=National Drug Code (NDC)
4Ø7-D7	PRODUCT/SERVICE ID	M	ID of the product dispensed or service provided.	x(19)	19		The 11-digit national drug code for the drug dispensed.
442-E7	QUANTITY DISPENSED	R	Quantity dispensed expressed in metric decimal units.	9(7)v999	1Ø		Required. Enter the ten digit metric decimal quantity of the drug dispensed in this field
4Ø3-D3	FILL NUMBER	R	The code indicating whether the prescription is an original or a refill.	9(2)	2	Ø = Original dispensing 1 to 99 = Refill number	Required. Alabama only allows value of ØØ thru 11 based on the NDC.
4Ø5-D5	DAYS SUPPLY	R	Estimated number of days the prescription will last.	9(3)	3		Required. Enter the estimated days supply of the drug dispensed. Alabama only allows value of <= 34.
4Ø6-D6	COMPOUND CODE	R	Code indicating whether or not the prescription is a compound.	9(1)	1	1 = Not a Compound 2 = Compound	Required.

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
4Ø8-D8	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	R	Code indicating whether or not the prescriber's instructions regarding generic substitution were followed.	x(1)	1	Ø = No Product Selection Indicated 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed-Patient Requested Product Dispensed 3 = Substitution Allowed-Pharmacist Selected Product Dispensed 4 = Substitution Allowed-Generic Drug Not in Stock 5 = Substitution Allowed-Brand Drug Dispensed as a Generic 6 = Override 7 = Substitution Not Allowed-Brand Drug Mandated by Law 8 = Substitution Allowed-Generic Drug Not Available in Marketplace 9 = Substitution Allowed By Prescriber but Plan Requests Brand – Patient's Plan Requested Brand Product To Be Dispensed	Values Ø, 1, 3, 4, 5, 7 and 8 are allowed. Values 2, 6 and 9 not allowed per state policy.
414-DE	DATE PRESCRIPTION WRITTEN	R	Date prescription was written.	9(8)	8		Required. Prescribe date in CCYYMMDD format.
419-DJ	PRESCRIPTION ORIGIN CODE	Q	Code indicating the origin of the prescription.	9(1)	1	Ø = Not Known 1 = Written 2 = Telephone 3 = Electronic 4 = Facsimile 5 = Pharmacy	Required for Alabama Medicaid.
354-NX	SUBMISSION CLARIFICATION CODE COUNT	Q	Count of the 'Submission Clarification Code' (42Ø-DK) occurrences.	9(1)	1		Maximum count of 3.

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
42Ø-DK	SUBMISSION CLARIFICATION CODE	Q***R***	Code indicating that the pharmacist is clarifying the submission.	9(2)	2	1 = No Override 2 = Other Override 3 = Vacation Supply 4 = Lost Prescription 5 = Therapy Change 6 = Starter Dose 7 = Medically Necessary 8 = Process Compound For Approved Ingredients 9 = Encounters 1Ø = Meets Plan Limitations 11 = Certification on File 12 = DME Replacement Indicator 13 = Payer-Recognized Emergency/Disaster Assistance Request 14 = Long Term Care Leave of Absence 15 = Long Term Care Replacement Medication 16 = Long Term Care Replacement box (kit) or automated dispensing machine 17 = Long Term Care Emergency supply reminder 18 = Long Term Care Patient Admit/Readmit Indicator 19 = Split Billing 99 = Other	8 or Ø8 as necessary to process approved compound ingredients. Otherwise N/A.
3Ø8-C8	OTHER COVERAGE CODE	Q	Code indicating whether or not the patient has other insurance coverage.	9(2)	2	ØØ = Not Specified Ø1 = No other coverage Ø2 = Other coverage exists-payment collected Ø3 = Other coverage exists- claim not covered Ø4 = Other coverage exists-payment not collected Ø8 = Claim is billing for copay	Optional. Default to Ø1 if nothing entered. Ø1 = No other coverage Ø2 = Other coverage exists-payment collected Ø3 = Other coverage exists-claim not covered Ø4 = Other coverage exists-payment not collected
418-DI	LEVEL OF SERVICE	Q	Coding indicating the type of service the provider rendered.	9(2)	2	Ø = Not Specified 1 = Patient consultation 2 = Home delivery 3 = Emergency 4 = 24 hour service 5 = Patient consultation regarding generic product selection 6 = In-Home Service	

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
461-EU	PRIOR AUTHORIZATION TYPE CODE	Q	Code clarifying the 'Prior Authorization Number Submitted' (462-EV) or benefit/plan exemption.	9(2)	2	Ø=Not Specified 1 = Prior Authorization 2 = Medical Certification 3 = EPSDT (Early Periodic Screening Diagnosis Treatment) 4 = Exemption from Copay and/or Coinsurance 5 = Exemption from RX 6 = Family Planning Indicator 7 = TANF (Temporary Assistance for Needy Families) 8 = Payer Defined Exemption 9 = Emergency Preparedness	Value of '1' or 'Ø1' when applicable, to indicate Prior Authorization. A value of '4' in 461-EU will indicate the recipient is a Native American Indian with an active user letter and is exempt from co-payment.
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	Q	Number submitted by the provider to identify the prior authorization.	9(11)	11		Prior Authorization number when (461-EU) equals '1' or 'Ø1'
343-HD	DISPENSING STATUS	Q	Code indicating the quantity dispensed is a partial fill or the completion of a partial fill. Used only in situations where inventory shortages do not allow the full quantity to be dispensed.	x(1)	1	P = Partial Fill C = Completion of Partial Fill	
344-HF	QUANTITY INTENDED TO BE DISPENSED	Q	Metric decimal quantity of medication that would be dispensed on original filling if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	9(7)V999	1Ø		
345-HG	DAYS SUPPLY INTENDED TO BE DISPENSED	Q	Days supply for metric decimal quantity of medication that would be dispensed on original dispensing if inventory were available. Used in association with a 'P' or 'C' in 'Dispensing Status' (343-HD).	9(3)	3		

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
357-NV	DELAY REASON CODE	Q	Code to specify the reason that submission of the transactions has been delayed.	9(2)	2	1 = Proof of eligibility unknown or unavailable 2 = Litigation 3 = Authorization delays 4 = Delay in certifying provider 5 = Delay in supplying billing forms 6 = Delay in delivery of custom-made appliances 7 = Third party processing delay 8 = Delay in eligibility determination 9 = Original claims rejected or denied due to a reason unrelated to the billing limitation rules 1Ø = Administration delay in the prior approval process 11 = Other 12 = Received late with no exceptions 13 = Substantial damage by fire, etc to provide records 14 = Theft, sabotage/other willful acts by employee	
391-MT	PATIENT ASSIGNMENT INDICATOR (DIRECT MEMBER REIMBURSEMENT INDICATOR)	Q	Code to indicate a patient's choice on assignment of benefits.	X(1)	1	Y = Patient assigns benefits – Patient has assigned benefits to another party N = Patient does not assign benefits – Patient has not assigned benefits to another party	
995-E2	ROUTE OF ADMINISTRATION	Q	This is an override to the "default" route referenced for the product. For a multi-ingredient compound, it is the route of the complete compound mixture.	x(11)	11	Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT) SNOMED CT® terminology which is available from the College of American Pathologists, Northfield, Illinois http://www.snomed.org/	

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
996-G1	COMPOUND TYPE	Q	Clarifies the type of compound.	X(2)	2	Ø1=Anti-infective Ø2= Ionotropic Ø3 =Chemotherapy Ø4= Pain management Ø5=TPN/PPN (Hepatic, Renal, Pediatric) Total Parenteral Nutrition/ Peripheral Parenteral Nutrition Ø6=Hydration Ø7=Ophthalmic 99=Other	
147-U7	PHARMACY SERVICE TYPE	Q	The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed.	9(2)	2	1 = Community/Retail Pharmacy Services 2 = Compounding Pharmacy Services 3 = Home Infusion Therapy Provider Services 4 = Institutional Pharmacy Services 5 = Long Term Care Pharmacy Services 6 = Mail Order Pharmacy Services 7 = Managed Care Organization Pharmacy Services 8 = Specialty Care Pharmacy Services 99 = Other	

Prescriber Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø3 = Prescriber	Ø3 = Prescriber Segment is mandatory.
466-EZ	PRESCRIBER ID QUALIFIER	Q	Code qualifying the 'Prescriber ID' (411-DB).	x(2)	2	Ø1 = National Provider Identifier (NPI) Ø2 = Blue Cross Ø3 = Blue Shield Ø4 = Medicare Ø5 = Medicaid Ø6 = UPIN Ø8 = State License Ø9 = CHAMPUS 1Ø = Health Industry Number (HIN) 11 = Federal Tax ID 12 = Drug Enforcement Administration (DEA) Number 13 = State Issued 14 = Plan Specific 15 = HC ID (HC IDea) 99 = Other	Required. Ø1 = National Provider Identifier (NPI) or Ø8 = State license number – Will continue to be accepted in place of the NPI number.
411-DB	PRESCRIBER ID	Q	ID assigned to the prescriber.	x(15)	15		Required. Based on the Prescriber ID Qualifier field, this reports either the 1Ø digit NPI Number or the state license number of the prescribing practitioner.
364-2J	PRESCRIBER FIRST NAME	Q	Individual first name.	x(12)	12		
365-2K	PRESCRIBER STREET ADDRESS	Q	Free form text for prescriber address information.	x(3Ø)	3Ø		
366-2M	PRESCRIBER CITY ADDRESS	Q	Free form text for prescriber city name.	x(2Ø)	2Ø		
367-2N	PRESCRIBER STATE/PROVINCE ADDRESS	Q	Standard state /province code as defined by appropriate government agency.	X(2)	2		
368-2P	PRESCRIBER ZIP/POSTAL ZONE	Q	Code defining international postal zone excluding punctuation and blanks.	x(15)	15		

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø5 = Coordination of Benefits/Other Payments	Ø5 = Coordination of Benefits/Other Payments Segment is situational.
337-4C	COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT	M	Count of other payment occurrences.	9(1)	1		Up to 9 occurrences will be used.
338-5C	OTHER PAYER COVERAGE TYPE	M***R***	Code identifying the type of 'Other Payer ID' (34Ø-7C).	x(2)	2	Blank=Not Specified Ø1 = Primary Ø2 = Secondary Ø3 = Tertiary Ø4 = Quaternary Ø5 = Quinary Ø6 = Senary Ø7 = Septenary Ø8 = Octonary Ø9 = Nonary	
339-6C	OTHER PAYER ID QUALIFIER	Q***R***	Code qualifying the 'Other Payer ID' (34Ø-7C).	x(2)	2	Ø1 = National Payer ID 1C = Medicare Number 1D = Medicaid Number Ø2 = Health Industry Number (HIN) Ø3 = Bank Information Number (BIN) Ø4 = National Association of Insurance Commissioners (NAIC) Ø5 = Medicare Carrier Number 99=Other	
34Ø-7C	OTHER PAYER ID	Q***R***	ID assigned to the payer.	x(1Ø)	1Ø		
443-E8	OTHER PAYER DATE	Q***R***	Payment or denial date of the claim submitted to the other payer. Used for coordination of benefits.	9(8)	8		Format = CCYYMMDD. Optional, will capture if sent.
993-A7	INTERNAL CONTROL NUMBER	Q***R***	Number assigned by the processor to identify an adjudicated claim when supplied in payer-to-payer coordination of benefits only.	X(3Ø)	3Ø		
341-HB	OTHER PAYER AMOUNT PAID COUNT	Q	Count of the payer amount paid occurrences.	9(1)	1		Up to 9 occurrences will be used.
342-HC	OTHER PAYER AMOUNT PAID QUALIFIER	Q***R***	Code qualifying the 'Other Payer Amount Paid' (431-DV).	x(2)	2	Ø1 = Delivery Ø2 = Shipping Ø3 = Postage Ø4 = Administrative Ø5 = Incentive Ø6 = Cognitive Service Ø7 = Drug Benefit Ø9 = Compound Preparation Cost	Value 07 or 09 should be used to denote other payer amounts paid.

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
431-DV	OTHER PAYER AMOUNT PAID	Q***R***	Amount of any payment known by the pharmacy from other sources (including coupons).	s9(6)v99	8		Enter the total amount paid by all other insurers.
353-NR	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT COUNT	Q	Count of "Other Payer-Patient Responsibility Amount" (352-NQ) and "Other Payer-Patient Responsibility Amount Qualifier" (351-NP) occurrences.	9(2)	2	Max of 25.	
351-NP	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT QUALIFIER	Q***R***	Code qualifying the "Other Payer-Patient Responsibility Amount (352-NQ)".	X(2)	2	Blank=Not Specified Ø1 = Amount Applied to Periodic Deductible Ø2 = Amount Attributed to Product Selection/Brand Drug Ø3 = Amount Attributed to Sales Tax Ø4 = Amount Exceeding Periodic Benefit Maximum Ø5 = Amount of Copay Ø6 = Patient Pay Amount Ø7 = Amount of Coinsurance Ø8 = Amount Attributed to Product Selection/Non-Preferred Formulary Selection Ø9 = Amount Attributed to Health Plan Assistance Amount 1Ø = Amount Attributed to Provider Network Selection 11 = Amount Attributed to Product Selection/Brand Non-Preferred Formulary Selection 12 = Amount Attributed to Coverage Gap 13 = Amount Attributed to Processor Fee	Value 06 should be used to specify the total amount of patient responsibility.
352-NQ	OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT	Q***R***	The patient's cost share from a previous payer.	s9(8)v99	1Ø		
392-MU	BENEFIT STAGE COUNT	Q	Count of 'Benefit Stage Amount' (394-MW) occurrences.	9(1)	1	Max count of 4.	

COB / Other Payments Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
393-MV	BENEFIT STAGE QUALIFIER	Q***R***	Code qualifying the 'Benefit Stage Amount' (394-MW).	x(2)	2	Ø1 = Deductible Ø2 = Initial Benefit Ø3 = Coverage Gap (donut hole) Ø4 = Catastrophic Coverage	
394-MW	BENEFIT STAGE AMOUNT	Q***R***	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).	s9(6)v99	8		

Worker's Compensation Segment: Not Used

This segment will not be used in Alabama.

DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø8 = DUR/PPS	Ø8 = DUR/PPS Segment is situational.
473-7E	DUR/PPS CODE COUNTER	Q***R***	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		Only first occurrence of 439-E4, 44Ø-E5 and 441-E6 will be used in processing the claim.
439-E4	REASON FOR SERVICE CODE	Q***R***	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse PA = Drug-Age PS = Product Selection TD = Therapeutic Duplication
44Ø-E5	PROFESSIONAL SERVICE CODE	Q***R***	Code identifying pharmacist intervention when a conflict code has been identified or service has been rendered.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	ØØ = No intervention MØ = Prescriber consulted PØ = Patient consulted RØ = Pharmacist consulted other source
441-E6	RESULT OF SERVICE CODE	Q***R***	Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	1A = Filled As is, False Positive 1B = Filled Prescription As is 1C = Filled, With Different Dose 1D = Filled, With Different Directions 1E = Filled, With Different Drug 1F = Filled, With Different Quantity 1G = Filled, With Prescriber Approval 1H = Brand-to-Generic Change 1K = Filled with Different Dosage Form 2A = Prescription Not Filled 2B = Not Filled, Directions Clarified

Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	11 = Pricing	11 = Pricing Segment is mandatory.
4Ø9-D9	INGREDIENT COST SUBMITTED	R	Submitted product component cost of the dispensed prescription. This amount is included in the 'Gross Amount Due' (43Ø-DU).	s9(6)v99	8		
438-E3	INCENTIVE AMOUNT SUBMITTED	Q	Amount represents a fee that is submitted by the pharmacy for contractually agreed upon services. This amount is included in the 'Gross Amount Due' (43Ø-DU).	s9(6)v99	8		
426-DQ	USUAL AND CUSTOMARY CHARGE	Q	Amount charged cash customers for the prescription exclusive of sales tax or other amounts claimed.	s9(6)v99	8		Required. Format = $$$$$$cc If field 426-DQ is submitted, the lower of this field and the amount sent in 43Ø -DU (gross amt due) will be used as the amount billed by the submitter.

Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
43Ø-DU	GROSS AMOUNT DUE	R	Total price claimed from all sources. For prescription claim request, field represents a sum of 'Ingredient Cost Submitted' (4Ø9-D9), 'Dispensing Fee Submitted' (412-DC), 'Flat Sales Tax Amount Submitted'(481-HA), 'Percentage Sales Tax Amount Submitted' (482-GE), 'Incentive Amount Submitted' (438-E3), 'Other Amount Claimed' (48Ø-H9). For service claim request, field represents a sum of 'Professional Services Fee Submitted' (477-BE), 'Flat Sales Tax Amount Submitted' (481-HA), 'Percentage Sales Tax Amount Submitted'(482-GE), 'Other Amount Claimed' (48Ø-H9).	s9(6)v99	8		Required. Format = $$$$$$cc.
423-DN	BASIS OF COST DETERMINATION	Q	Code indicating the method by which 'Ingredient Cost Submitted' (Field 4Ø9-D9) was calculated.	x(2)	2	ØØ = Default Ø1 = AWP (Average Wholesale Price) Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB /Disproportionate Share Pricing/Public Health Service Ø9=Other 1Ø=ASP (Average Sales Price) 11=AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	

Coupon Segment: Not Used

This segment will not be used in Alabama.

Compound Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	1Ø = Compound	1Ø = Compound Segment is situational.
45Ø-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	M	Dosage form of the complete compound mixture.	x(2)	2	Blank=Not Specified Ø1 = Capsule Ø2 = Ointment Ø3 = Cream Ø4 = Suppository Ø5 = Powder Ø6 = Emulsion Ø7 = Liquid 1Ø = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema	
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	M	NCPDP standard product billing codes.	9(1)	1	1 = Each 2 = Grams 3 = Milliliters	
447-EC	COMPOUND INGREDIENT COMPONENT COUNT	M	Count of compound product IDs (both active and inactive) in the compound mixture submitted.	9(2)	2		A count of 1 to 25 allowed.
488-RE	COMPOUND PRODUCT ID QUALIFIER	M***R***	Code qualifying the type of product dispensed.	x(2)	2	See Appendix K - Product/Service Qualifier	Ø3 One to twenty-five occurrences allowed.
489-TE	COMPOUND PRODUCT ID	M***R***	Product identification of an ingredient used in a compound.	x(19)	19		Enter the 11 digit NDC number. One to twenty-five occurrences allowed.
448-ED	COMPOUND INGREDIENT QUANTITY	M***R***	Amount expressed in metric decimal units of the product included in the compound mixture.	9(7)v999	1Ø		Enter the metric decimal quantity of the drug dispensed. Field length of 1Ø One to twenty-five occurrences allowed.
449-EE	COMPOUND INGREDIENT DRUG COST	Q***R***	Ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in 'Compound Ingredient Quantity' (Field 448-ED).	s9(6)v99	8		Enter the ingredient cost. One to twenty-five occurrences allowed.

Compound Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	Q***R***	Code indicating the method by which the drug cost of an ingredient used in a compound was calculated.	x(2)	2	ØØ =Default Ø1 = AWP (Average Wholesale Price) Ø2 = Local Wholesaler Ø3 = Direct Ø4 = EAC (Estimated Acquisition Cost) Ø5 = Acquisition Ø6 = MAC (Maximum Allowable Cost) Ø7 = Usual & Customary Ø8 = 34ØB /Disproportionate Share Pricing/Public Health Service Ø9 = Other 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = WAC (Wholesale Acquisition Cost)	
362-2G	COMPOUND INGREDIENT MODIFIER CODE COUNT	Q	Code indicating the number of Compound Ingredient Modifier Code (363-2H)	9(2)	2		
363-2H	COMPOUND INGREDIENT MODIFIER CODE	Q***R***	Identifies special circumstances related to the dispensing/payment of the product as identified in the Compound Product ID (498-TE).	X(2)	2	Reference: Healthcare Common Procedure Coding System (HCPCS) available at www.cms.hhs.gov/medicare/hcpcs/	

Clinical Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	13 = Clinical	13 = Clinical Segment is situational.
491-VE	DIAGNOSIS CODE COUNT	Q	Count of diagnosis occurrences.	9(1)	1		Max count of 5.
492-WE	DIAGNOSIS CODE QUALIFIER	Q***R***	Code qualifying the 'Diagnosis Code' (424-DO).	x(2)	2	ØØ= Not Specified Ø1 = International Classification of Diseases (ICD9) Ø2 = International Classification of Diseases (ICD1Ø) Ø3 = National Criteria Care Institute (NCCI) Ø4 = The Systematized Nomenclature of Human and Veterinary Medicine (SNOMED) Ø5 = Common Dental Terminology (CDT) Ø6 = Medi-Span Product Line Diagnosis Code Ø7 = American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders(DSM IV) Ø8 = First DataBank Disease Code (FDBDX) Ø9 = First DataBank FML Disease Identifier (FDB DxID) 99 = Other	
424-DO	DIAGNOSIS CODE	Q***R***	Code identifying the diagnosis of the patient.	x(15)	15		1 occurrence allowed. Three to seven digit alpha/numeric code
493-XE	CLINICAL INFORMATION COUNTER	Q***R***	Counter number of clinical information measurement set/logical grouping.	9(1)	1		
494-ZE	MEASUREMENT DATE	Q***R***	Date clinical information was collected or measured.	9(8)	8		Format = CCYYMMDD
495-H1	MEASUREMENT TIME	Q***R***	Time clinical information was collected or measured.	9(4)	4		Format = HHMM

Clinical Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
496-H2	MEASUREMENT DIMENSION	Q***R***	Code indicating the clinical domain of the observed value in 'Measurement Value' (499-H4).	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
497-H3	MEASUREMENT UNIT	Q***R***	Code indicating the metric or English units used with the clinical information.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
499-H4	MEASUREMENT VALUE	Q***R***	Actual value of clinical information.	x(15)	15	Blood pressure entered in XXX/YYY format in which XXX=systolic, /=divider, and YYY is diastolic. Temperature entered in XXX.X format always including decimal point.	

Billing Paid Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo from B1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	P
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		13 digit ICN (internal control number) assigned to paid claim.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	Will be used to put EOB message concerning how the claim paid.

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	23 = Response Pricing	23
5Ø5-F5	PATIENT PAY AMOUNT	R	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, et	s9(6)v99	8	Format 999999.99	Total amount of copay to be paid by the patient.
5Ø6-F6	INGREDIENT COST PAID	Q	Drug ingredient cost paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	Total amount that will be paid for the drug dispensed.
5Ø7-F7	DISPENSING FEE PAID	Q	Dispensing fee paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	The dispensing fee amount that will be paid for this claim (system generated).
5Ø9-F9	TOTAL AMOUNT PAID	R	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive	s9(6)v99	8	Format 999999.99	Total amount that will be paid to the provider for this claim.

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Q	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	9(2)	2	Ø = Not Specified 1 = Ingredient Cost Paid as Submitted 2 = Ingredient Cost Reduced to AWP Pricing 3 = Ingredient Cost Reduced to AWP Less X% Pricing 4 = Usual & Customary Paid as Submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual and Customary 6 = MAC Pricing Ingredient Cost Paid 7 = MAC Pricing Ingredient Cost Reduced to MAC 8 = Contract Pricing 9 = Acquisition Pricing 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12= 34ØB/Disproportionate Share/Public Health Service Pricing 13 = WAC (Wholesale Acquisition Cost) 14 = Other Payer-Patient Responsibility Amount 15 = Patient Pay Amount 16 = Coupon Payment	Value of Ø = DOJ Value of 1 = the billed amt was less than the allowed/calculated amt Value of 3 = paid the AWP price less X% Pricing Value of 4 = Usual & Customary Value of 6 = paid at MAC or FUL price Value of 9 = paid at AAC price Value of 13 = paid at WAC price plus X% Value of 14 = Other Payer-Patient Responsibility Amount
518-FI	AMOUNT OF COPAY	Q	Amount to be collected from the patient that is included in 'Patient Pay Amount' (5Ø5-F5) that is due to a per prescription copay.	s9(6)v99	8		The value returned is the same as 5Ø5-F5 for the paid B1 claim.

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
53Ø-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	1Ø		
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(3Ø)	3Ø		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Billing Rejected Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		This field will contain the number of errors generated, as well as the internal four digit numbers that correspond to the rejection or informational codes generated on the transaction. Format will be AAXXXXYYYYZZZZ where AA will indicate the number of codes, and XXXX, YYYY, and ZZZZ would represent the internal error codes or informational codes generated on the transaction.

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Rejected Response (B1)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	R
51Ø-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		1 to 5
511-FB	REJECT CODE	R***R*** (up to 5)	Code indicating the error encountered.	x(3)	3	See NCPDP D.Ø Data Dictionary.	The two digit NCPDP reject code.
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R*** (up to 5)	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		On multiple detail transactions, this field will reflect the detail number to which the reject code applies.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	This field will contain the text descriptions that correspond to the codes returned in the Response Message segment, field 5Ø4-F4. Each description will be no more than 4Ø bytes in length, and will be separated by a semi-colon.

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		1 - 3 allowed
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	DD = Drug-Drug Interaction ER = Overuse HD = High Dose LD = Low Dose LR = Underuse PA = Drug-Age PS = Product Selection TD = Therapeutic Duplication
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
529-FT	OTHER PHARMACY INDICATOR	Q***R*** (up to 3)	Code indicating the pharmacy responsible for the previous event involved in the DUR conflict.	9(1)	1	Ø = Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	
53Ø-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		Format = CCYYMMDD
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	1Ø		Format = 9999999V999.
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	Blank = Not Specified 1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(3Ø)	3Ø		1 - 3Ø characters.

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Billing Duplicate Response (B1 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B1 = Billing	B1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B1 request.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		This field will contain the number of errors generated, as well as the internal four digit numbers that correspond to the rejection or informational codes generated on the transaction. Format will be AAXXXXYYYYZZZZ where AA will indicate the number of codes, and XXXX, YYYY, and ZZZZ would represent the internal error codes or informational codes generated on the transaction

Response Insurance Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment: Not Used

This segment will not be used in Alabama.

Claim Billing Duplicate Billing Response (B1)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved B = Benefit C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	D
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		13 digit ICN (internal control number) assigned to previously paid claim.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	This will be a 4Ø byte message field indicating additional information. For a duplicate, a message indicating the transaction is a duplicate will appear in the 4Ø byte area, followed by the date the claim was submitted. If the pharmacy billing the transaction is different from the claim in history, a message indicating only the ICN will appear in the 4Ø byte area.

Claim Billing Duplicate Billing Response (B1)

Response Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	Echo back from B1 request.
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B1 request.

Claim Billing Duplicate Billing Response (B1)

Response Pricing Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	23 = Response Pricing	23
5Ø5-F5	PATIENT PAY AMOUNT	R	Amount that is calculated by the processor and returned to the pharmacy as the TOTAL amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, et	s9(6)v99	8	Format 999999.99	Total amount of copay paid by the patient on the claim in history. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
5Ø6-F6	INGREDIENT COST PAID	Q	Drug ingredient cost paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	Total amount that was paid for the drug dispensed. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
5Ø7-F7	DISPENSING FEE PAID	Q	Dispensing fee paid included in the 'Total Amount Paid' (5Ø9-F9).	s9(6)v99	8	Format 999999.99	The dispensing fee amount that was paid for this claim. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
5Ø9-F9	TOTAL AMOUNT PAID	R	Total amount to be paid by the claims processor (i.e. pharmacy receivable). Represents a sum of 'Ingredient Cost Paid' (5Ø6-F6), 'Dispensing Fee Paid' (5Ø7-F7), 'Flat Sales Tax Amount Paid' (558-AW), 'Percentage Sales Tax Amount Paid' (559-AX), 'Incentive	s9(6)v99	8	Format 999999.99	Total amount that was paid to the provider for the claim in history. If the pharmacy billing the claim is different than the one in history, or if the claim is more than seven days old, this field will be zero.
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	Q	Code identifying how the reimbursement amount was calculated for 'Ingredient Cost Paid' (5Ø6-F6).	9(2)	2	Ø = Not Specified 1 = Ingredient Cost Paid as Submitted 2 = Ingredient Cost Reduced to AWP Pricing 3 = Ingredient Cost Reduced to AWP Less X% Pricing 4 = Usual & Customary Paid as Submitted 5 = Paid Lower of Ingredient Cost Plus Fees Versus Usual and Customary 6 = MAC Pricing Ingredient paid 7 = MAC Pricing Ingredient Cost Reduced to MAC 8 = Contract Pricing 9 = Acquisition Pricing 1Ø = ASP (Average Sales Price) 11 = AMP (Average Manufacturer Price) 12 = 34ØB/Disproportionate Share/Public Health Service Pricing 13 = WAC (Wholesale Acquisition Cost) 14 = Other Payer-Patient Responsibility Amount 15 = Patient Pay Amount 16 = Coupon Payment	Value is based on claim processing rules.

Response DUR / PPS Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	24 = Response DUR/PPS	24
567-J6	DUR/PPS CODE COUNTER	Q***R*** (up to 3)	Counter number for each DUR/PPS set/logical grouping.	9(1)	1		
439-E4	REASON FOR SERVICE CODE	Q***R*** (up to 3)	Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service.	x(2)	2	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
528-FS	CLINICAL SIGNIFICANCE CODE	Q***R*** (up to 3)	Code identifying the significance or severity level of a clinical event as contained in the originating data base.	x(1)	1	Blank=Not Specified 1 = Major 2 = Moderate 3 = Minor 9 = Undetermined	
529-FT	OTHER PHARMACY INDICATOR	Q***R*** (up to 3)	Code indicating the pharmacy responsible for the previous event involved in the DUR conflict.	9(1)	1	Ø=Not Specified 1 = Your Pharmacy 2 = Other Pharmacy in Same Chain 3 = Other Pharmacy	
53Ø-FU	PREVIOUS DATE OF FILL	Q***R*** (up to 3)	Date prescription was previously filled.	9(8)	8		
531-FV	QUANTITY OF PREVIOUS FILL	Q***R*** (up to 3)	Amount expressed in metric decimal units of the conflicting agent that was previously filled.	9(7)v999	1Ø		
532-FW	DATABASE INDICATOR	Q***R*** (up to 3)	Code identifying the source of drug information used for DUR processing.	x(1)	1	1 = First Databank 2 = Medi-Span Product Line 3 = Micromedex/Medical Economics 4 = Processor Developed 5 = Other 6 = Redbook 7 = Multum	1
533-FX	OTHER PRESCRIBER INDICATOR	Q***R*** (up to 3)	Code comparing the prescriber of the current prescription to the prescriber of the previously filled conflicting prescription.	9(1)	1	Ø = Not Specified 1 = Same Prescriber 2 = Other Prescriber	
544-FY	DUR FREE TEXT MESSAGE	Q***R*** (up to 3)	Text that provides additional detail regarding a DUR conflict.	x(3Ø)	3Ø		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Reversal Transaction (B2 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card Issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	x(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1 = One Occurrence (only one reversal will be permitted on a transmission)
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		10 digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	x(1Ø)	1Ø		N/A

Insurance Segment: Not Used

This segment will not be used in Alabama.

Claim Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	Ø7 = Claim	Ø7
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 =Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Twelve digit numeric prescription number.
436-E1	PRODUCT/ SERVICE ID QUALIFIER	M	Code qualifying the value in 'Product/Service ID' (4Ø7-D7).	x(2)	2	Ø3 = National Drug Code	Ø3
4Ø7-D7	PRODUCT/ SERVICE ID	M	ID of the product dispensed or service provided.	x(19)	19		The 11-digit national drug code for the drug dispensed.

DUR/PPS Segment: Not Used

This segment will not be used in Alabama.

Pricing Segment: Not Used

This segment will not be used in Alabama.

Coordination of Benefits/Other Payments Segment: Not Used

This segment will not be used in Alabama.

Reversal Approval Response (B2 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo back from B2 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B2 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B2 request.

Claim Reversal Approval Response (B2)

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Claim Reversal Approval Response (B2)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	A = Approved C = Captured D = Duplicate of Paid F = PA Deferred P = Paid Q = Duplicate of Capture R = Rejected S = Duplicate of Approved	A = Approved
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		For a Claim Reversal, the authorization number will be the 13 digit voided ICN #.
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 =Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/ SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/ SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B2 request.

Reversal Rejection Response (B2 Response)

Response Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	x(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	x(2)	2	B2 = Claim Reversal	B2
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission.	x(1)	1	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	1
5Ø1-F1	HEADER RESPONSE STATUS	M	Code indicating the status of the transmission.	x(1)	1	A = Accepted R = Rejected	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID' (2Ø1-B1).	x(2)	2	Ø1 = National Provider Identifier (NPI)	Echo from B2 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider.	x(15)	15		Echo back from B2 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies date the prescription was filled or professional service rendered.	9(8)	8		Echo back from B2 request.

Response Message Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	2Ø = Response Message	2Ø
5Ø4-F4	MESSAGE	Q	Free form message.	x(1)-x(2ØØ)	1-2ØØ		

Claim Reversal Rejection Response (B2)

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	R = Rejected	R
5Ø3-F3	AUTHORIZATION NUMBER	Q	Number assigned by the processor to identify an authorized transaction.	x(2Ø)	2Ø		
51Ø-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		Number of rejection codes set on the reversal txn.
511-FB	REJECT CODE	R***R*** (up to 5)	Code indicating the error encountered.	x(3)	3		NCPDP two-digit rejection code that applies.
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R*** (up to 5)	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	4Ø	Comments: The maximum length of field is 4Ø characters.	

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	22 = Response Claim	22
455-EM	PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER	M	Indicates the type of billing submitted.	x(1)	1	1 = Rx Billing 2 = Service Billing	1
4Ø2-D2	PRESCRIPTION/SERVICE REFERENCE NUMBER	M	Reference number assigned by the provider for the dispensed drug/product and/or service provided.	9(12)	12		Echo back from B2 request.

Eligibility Request Transaction (E1 Request)

Transaction Header Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø1-A1	BIN NUMBER	M	Card issuer ID or Bank ID Number used for network routing.	9(6)	6	ØØ4146	ØØ4146
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary.	X(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
1Ø4-A4	PROCESSOR CONTROL NUMBER	M	Number assigned by the processor.	X(1Ø)	1Ø		N/A
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1 = One Occurrence	1
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2	Ø1 = National Provider Identifier (NPI)	Ø1
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		10 digit NPI Number
4Ø1-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Format = CCYYMMDD
11Ø-AK	SOFTWARE VENDOR/ CERTIFICATION ID	M	ID assigned by the switch or processor to identify the software source.	X(1Ø)	1Ø		N/A

Insurance Segment: Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	Ø4 = Insurance	Ø4
3Ø2-C2	CARDHOLDER ID	M	Insurance ID assigned to the cardholder.	X(2Ø)	2Ø		Enter first12 digits of Medicaid ID number.

Patient Segment: Not Used

This segment will not be used in Alabama.

Pharmacy Provider Segment: Not Used

This segment will not be used in Alabama.

Prescriber Segment: Not Used

This segment will not be used in Alabama.

Additional Documentation Segment: Not Used

This segment will not be used in Alabama.

Eligibility Response Approved Transaction (E1 Response)

Response Header Segment– Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	X(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1, 2, 3, 4	1=One Occurrence
5Ø1-F1	HEADER RESPONSE STATUS	M	Response Status	X(1)	1	A = Accepted R = Rejected	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2		Echo back from E1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		Echo back from E1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Echo back from E1 request.

Response Message Segment: Not Used

This segment will not be used in Alabama.

Response Insurance Segment– Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	25 = Response Insurance	25
3Ø2-C2	CARDHOLDER ID	Q	Insurance ID assigned to the cardholder.	x(2Ø)	2Ø		Echo back from E1 request.

Response Insurance Additional Information Segment: Not Used

This segment will not be used in Alabama.

Response Patient Segment – Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	X(2)	2	29 = Response Patient	29
31Ø-CA	PATIENT FIRST NAME	Q	Individual first name.	x(12)	12		
311-CB	PATIENT LAST NAME	Q	Individual last name.	x(15)	15		
3Ø4-C4	DATE OF BIRTH	Q	Date of birth of patient.	9(8)	8		

Response Status Segment: Transaction Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATTION	M	Identifies the segment in the request and/or response.	X(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	X(1)	1	A = Approved	A
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free form text message.	x(1)-x(4Ø)	1-4Ø		

Response Coordination of Benefits/Other Payers Segment: Not Used

This segment will not be used in Alabama.

Eligibility Response Rejected Transaction (E1 Response)

Response Header Segment – Transmission Level

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
1Ø2-A2	VERSION/ RELEASE NUMBER	M	Code uniquely identifying the transmission syntax and corresponding Data Dictionary	X(2)	2	DØ = Version D.Ø	DØ
1Ø3-A3	TRANSACTION CODE	M	Code identifying the type of transaction.	X(2)	2	E1 = Eligibility Verification	E1
1Ø9-A9	TRANSACTION COUNT	M	Count of transactions in the transmission	X(1)	1	1, 2, 3, 4	1=One Occurrence
5Ø1-F1	HEADER RESPONSE STATUS	M	Response Status	X(1)	1	A = Accepted R = Rejected	
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Code qualifying the 'Service Provider ID.'	X(2)	2		Echo back from E1 request.
2Ø1-B1	SERVICE PROVIDER ID	M	ID assigned to a pharmacy or provider	X(15)	15		Echo back from E1 request.
4Ø1-D1	DATE OF SERVICE	M	Identifies the date a prescription is to be filled or professional service is to be rendered	9(8)	8		Echo back from E1 request.

Field	Field Name	Data Element Usage	Definition of Field	Field Format	Field Length	Values	Alabama Requirements
111-AM	SEGMENT IDENTIFICATION	M	Identifies the segment in the request and/or response.	x(2)	2	21 = Response Status	21
112-AN	TRANSACTION RESPONSE STATUS	M	Code indicating the status of the transaction.	x(1)	1	R = Rejected	R
51Ø-FA	REJECT COUNT	R	Count of 'Reject Code' (511-FB) occurrences.	9(2)	2		
511-FB	REJECT CODE	R***R***	Code indicating the error encountered.	X(3)	3	Refer to the NCPDP External Code List dated June 2ØØ8 Appendix A.	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	Q***R***	Identifies the counter number or occurrence of the field that is being rejected. Used to indicate rejects for repeating fields.	9(2)	2		
13Ø-UF	ADDITIONAL MESSAGE INFORMATION COUNT	Q	Count of the 'Additional Message Information' (526-FQ) occurrences that follow.	9(2)	2		
132-UH	ADDITIONAL MESSAGE INFORMATION QUALIFIER	Q***R***	Format qualifier of the 'Additional Message Information' (526-FQ) that follows. Each value may occur only once per transaction and values must be ordered sequentially (numeric characters precede alpha characters, i.e., Ø-9, A-Z).	X(2)	2	Ø1 = Used for first line of free form text with no pre-defined structure. Ø2 = Second line. Ø3 = Third line. Ø4 = Fourth line. Ø5 = Fifth line. Ø6 = Sixth line. Ø7 = Seventh line. Ø8 = Eighth line. Ø9 = Ninth line.	
526-FQ	ADDITIONAL MESSAGE INFORMATION	Q***R***	Free text message.	x(1)-x(4Ø)	1-4Ø		

Change Summary

This section details the changes between this version and the previous versions.

DATE	DOCUMENT VERSION	AUTHOR	Section/Page	DESCRIPTION OF CHANGE
09/08/2011	1.0	Sarah Hataway		Agency approved
10/03/2011	1.1	Sarah Hataway	Added a new requirement on page 4. Added a new Value and updated the Alabama Requirements on page 9.	Origin Prescription Code Verbiage added. 419-DJ – Value 5 = Pharmacy added. Alabama Requirements updated to state this is required.
10/19/2011	1.2	James Barnett	Added new clarification in the Other Insurance section on page 3. Revised values allowed for field 308-C8 (other coverage code) on page 3. Clarification made regarding the number of COB segments that will be processed on page 15. Added note regarding field 342-HC.	Verbiage revised regarding allowed values in field 342-HC. Value '08' was removed as a valid value for field 308-C8. Revised statement to clarify that up to 9 occurrence of COB information will be processed. Change made on fields 337-4C and 341-HB. Value 09 (Compound Preparation Cost) was added as a valid value for field 342-HC, note was updated indicating that either 07 or 09 will be interpreted as TPL-AMT in the Alabama Medicaid system.
10/26/2011	1.3	James Barnett	Corrected Testing Procedures section on Page 1. Corrected reversal transaction information on Page 4.	Removed sentences referring to test claims being provided to testers. HP has never provided test claims to vendors wishing to test. Clarified that Alabama Medicaid will support only one B2 reversal transaction on a transmission. This matches the specifications for 109-A9 (transaction count) on Page 45.